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SUPREME COURT OF THE UNITED STATES

MARK J. MILLS, MICHAEL GILL AND
WILLIAM MALAMUD,

Petitioners,

v.

RUBIE ROGERS, ABLE BOLDEN, BETTY BYBEL,
JAMES COLLERAN, DONNA HUNT,
WILLIE WADSWORTH, AND HAROLD WARNER,

Respondents.

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT
OF APPEALS FOR THE FIRST CIRCUIT

BRIEF OF PETITIONERS

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QUESTIONS PRESENTED

1. Whether involuntarily committed mental patients have a constitutional right to refuse treatment with antipsychotic medication?

2. Whether the procedures followed at the Austin and May Units of Boston State Hospital for forcibly medicating patients satisfied the requirements of procedural due process?

3. Whether involuntarily committed mental patients have a constitutional right to be treated with less restrictive alternatives than forcible medication?

4. Even if involuntarily committed mental patients have a constitutional right to refuse treatment, whether the Commonwealth has an overriding state interest in being allowed to forcibly medicate these patients with antipsychotic medications in situations other than (1) where a doctor believes in his professional judgment the

medication is necessary to prevent violence, and (2) where any delay could result in significant deterioration of the patient's mental health?

5. Even if involuntarily committed mental patients have a constitutional right to refuse treatment, whether the Commonwealth has an overriding state interest in being able to forcibly medicate these patients with antipsychotic medication in situations other than those posing a serious threat of personal injury, extreme violence or attempted suicide?

6. Whether the principles of federalism were violated when the United States Court of Appeals for the First Circuit remanded this case to the trial court to design creative procedural mechanisms for implementing a right to refuse treatment rather than allowing the state official defendants (who were found to have acted in good faith, in accordance with

acceptable medical practice and not to have violated "clearly established constitutional rights") to develop their own procedures?

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OPINIONS AND JUDGMENTS BELOW

The opinion of the Court of Appeals is reported at 634 F.2d 650 (1st Cir. 1980) and appears in the Appendix to the Petition for Certiorari at pp. 1a-39a. The judgment of the Court of Appeals appears in the Appendix to the Petition for Certiorari at pp. 40a-41a.

The opinion of the District Court for the District of Massachusetts is reported at 478 F.Supp. 1342 (D.Mass. 1979) and appears in the Appendix to the Petition for Certiorari at pp. 42a-161a. The judgment of the District Court appears in the Appendix to the Petition for Certiorari at pp. 162a-163a.

JURISDICTION

The judgment of the Court of Appeals for the First Circuit was entered on November 25, 1980. The petition for

certiorari was filed within 90 days of that date. This Court's jurisdiction is invoked under 28 U.S.C. § 2101(c).

CONSTITUTIONAL PROVISIONS, STATUTORY PROVISIONS AND REGULATIONS

See Constitutional Provisions, Statutes and Regulations set forth in the Joint Appendix, the Appendix to the Petition for Certiorari and the Appendix to this Brief.

STATEMENT OF THE CASE

On April 30, 1975, seven mental patients filed a complaint in the United States District Court, District of Massachusetts, seeking a permanent injunction and temporary restraining order ("TRO") enjoining the petitioners from forcibly confining in seclusion or medicating the patients and all other in-patients of the Austin and May Units, located at Boston State Hospital, without their consent or the consent of their guardians except where there was a serious

threat of or as a result of, extreme violence, personal injury or attempted suicide. Jurisdiction was invoked under 42 U.S.C. § 1983. On April 30, 1975, the trial court issued the temporary restraining order sought by plaintiffs.

Despite attempts by the petitioners to hold a hearing forthwith on plaintiffs' motion for a preliminary injunction and to dissolve the TRO, the TRO remained in effect until the issuance of a permanent injunction by the trial court on October 29, 1979.

On December 8, 1977, the trial of the case began in the District Court. The trial combined both the injunctive issues now before this Court as well as twenty-eight malpractice and civil rights cases brought against individual doctors. Seventy-two days of testimony were taken and the evidentiary portion of the trial concluded on January 31, 1979.

On October 29, 1979, the District Court issued an order and judgment which stated, in relevant part "that the defendants, their agents and employees, are restrained from forcibly . . . medicating the plaintiffs and all other inpatients of the Austin and May Units, and successor units, of the Boston State Hospital without the patient's consent or the consent of the patient's guardian, if any, except where there is a substantial likelihood of, or as a result of, extreme violence, personal injury or attempted suicide." Cert. App., pp. 162a-163a.[1/] The trial court also found that the defendants acted in good faith, in accordance with standards of reasonable medical practice, and did not violate any clearly established constitutional rights.

1/ Reference to the Appendix to the Petition for Certiorari shall appear as "Cert. App.". Reference to the Joint Appendix shall appear as "J.A.".

Cert. App., pp. 139a, 140a, 149a, 150a. Accordingly, the trial court denied all damage claims against the defendants.

Defendants Okin (Commissioner of the Massachusetts Department of Mental Health), Malamud (inpatient director of the Solomon Carter Fuller Mental Health Center, which is the May Unit's successor unit), and Gill (former inpatient director of the Johnson Unit of the Tufts-Bay Cove Mental Health Center, which is the Austin Unit's successor unit) noticed their appeal to the United States Court of Appeals for the First Circuit on November 19, 1979, from that part of the Court's order enjoining the forcible use of antipsychotic medication. Plaintiffs filed a cross-appeal from that part of the Court's order denying any damage recovery. On November 25, 1980, the First Circuit issued its opinion.

The First Circuit affirmed the trial

court's denial of damages. The First Circuit agreed that the record supported the trial court's findings that (1) defendants had acted in subjective good faith, (2) defendants had not violated "clearly established" constitutional rights, and (3) defendants had not acted negligently. Cert. App., pp. 32a-33a, 37a.

The First Circuit also agreed with the trial court's ruling that antipsychotic medication cannot be forcibly administered to involuntarily committed mental patients solely for treatment purposes absent an additional judicial finding of incompetency. Cert. App., p. 14a. On the other hand, the First Circuit apparently broadened the trial court's definition of emergency, declaring that patients could be forcibly medicated without a declaration of incompetency (1) where a doctor believes in his professional judgment that the

medication is necessary to prevent violence, Cert. App., pp. 7a-15a, and (2) where any delay could result in significant deterioration of the patient's mental health. Cert. App., pp. 24a-26a. Moreover, while the trial court's order forbid forcible medication in a non-emergency without the consent of the patient's guardian, the First Circuit stated that: "[a]s a constitutional matter, the state is not required to seek individualized guardian approval for decisions to treat incompetent patients with antipsychotic drugs." Cert. App., p. 30a.

The First Circuit issued an order declaring:

> Judgment affirmed in part, reversed in part, and vacated and remanded for further proceedings in accordance with this opinion.

Cert. App., p. 39a.

The First Circuit remanded the case to the trial court with instructions "to

be creative in designing procedural mechanisms" to enforce a mental patient's right to refuse treatment. Cert. App., pp. 14a-15a.

Despite the apparent contradictions between the First Circuit's opinion and the trial court's opinion and despite the First Circuit's order vacating the judgment, the trial court declared on remand on December 18, 1980 that as far as the trial court was concerned, its order stands and was not vacated. Cert. App., pp. 176a-178a. The trial court indicated that in its opinion only its order regarding voluntary patients had been reversed. Id., pp. 177a-178a. On December 22, 1980, the petitioners filed with the First Circuit a motion to clarify its order in light of the trial court's statements on December 18, 1980. On January 28, 1981, the First Circuit declined to clarify its opinion. Cert. App., pp. 164a-165a.

On February 20, 1981, defendants Okin,[2/] Gill and Malamud petitioned this Court for a Writ of Certiorari to the United States Court of Appeals for the First Circuit. On April 20, 1981, this Court allowed defendants' petition for a writ of certiorari.

SUMMARY OF ARGUMENT

I

Involuntarily committed mental patients do not have a constitutional right to refuse antipsychotic medication. The Commonwealth need only show a rational reason, and not a compelling state interest for imposing treatment on an involuntary patient, as treatment is directly related to the purpose for which mental patients in Massachusetts are committed. Antipsychotic medication is

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2/ On April 2, 1981, Mark J. Mills replaced Robert Okin as Commissioner of the Massachusetts Department of Mental Health.

essential to the treatment of major mental illness. Moreover, patients have no fundamental first amendment or privacy interest in refusing treatment. The Commonwealth assumes the decision-making role for mentally ill patients at the time of commitment; any further hearings tying treatment to judicial declarations of incompetency would be overly burdensome, anti-therapeutic and irrelevant.

While the Commonwealth need not show a compelling state interest in forcibly medicating involuntary patients, the Commonwealth has nevertheless met even this heavy burden. The extreme illness and potential violence of the patient population at state hospitals justifies forcible treatment with antipsychotic medication. The Commonwealth has a particularly compelling interest in preventing the chronicity and warehousing that would follow from allowing patients

to refuse their antipsychotic medication. It has been the introduction of antipsychotic medications which has permitted state hospitals to reduce their populations and which has made community programs possible for many patients who previously required hospitalization.

II

The procedures followed at the Austin and May Units when forcibly medicating patients satisfied the requirements of procedural due process. The decision to forcibly medicate was properly recognized as the type of decision peculiarly within the expertise of trained medical specialists. The lack of past abuse at the Austin and May Units, as well as the availability of other procedures to remedy any future abuses, also dictate against the provision of additional procedural safeguards.

III

Involuntarily committed mental patients do not have a constitutional right to be treated by less restrictive alternatives than forcible medication. The least restrictive means test is particularly inappropriate for the making of medical treatment decisions, as such a test would (1) require extensive judicial interference in daily hospital decisions and (2) inevitably militate in favor of the least possible treatment rather than the best possible treatment.

IV

Even if involuntary patients have a right to refuse treatment, the emergency exceptions recognized by the First Circuit are drawn too narrowly. The First Circuit would not permit forcible medication necessary to prevent the severe psychic suffering of major mental illness. Moreover, the First Circuit, in failing to

recognize the potential for impulsive violent behavior of all severely mentally ill patients, has created substantive rules likely to lead to an increase in violence at state hospitals.

V

The history of increased violence, suffering and staff turnover at the Austin and May Units after the temporary restraining order supports the Commonwealth's contention that there is a compelling state interest in forcibly medicating patients with antipsychotic medication.

VI

Even if the First Circuit correctly delineated the scope of a constitutional right to refuse treatment, this Court should nevertheless vacate the First Circuit's order remanding the case, in order to allow defendants to promulgate their own regulations consistent with the

substantive law as was set forth in the First Circuit opinion. Given the lower courts' findings that the defendants acted in good faith, non-negligently, and not in violation of clearly established constitutional rights, the First Circuit's remand to design creative procedures (1) violated the doctrine of federalism and (2) ignored principles of judicial restraint limiting the scope of injunctions to fit the nature of a violation.

ARGUMENT

I. INVOLUNTARILY COMMITTED MENTAL PATIENTS DO NOT HAVE A CONSTITUTIONAL RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION.

In determining whether a "right to refuse treatment" exists for an involuntary patient, this Court must evaluate (1) the interests of the patient in refusing treatment, (2) the interests of the Commonwealth in imposing the treatment, and (3) the inherent character

and purpose of commitment to a mental hospital. The patients have no fundamental constitutional interest in refusing treatment. Moreover, forcible medication is directly related to the purpose of commitment in Massachusetts. Thus, although the Commonwealth can show a compelling state interest in being permitted to medicate involuntary patients with antipsychotic drugs, the Commonwealth need not meet this heavy burden.

A. The Commonwealth Need Only Show a Rational Reason, and Not a Compelling State Interest, For Imposing Treatment on an Involuntary Patient.3/

1. The Commonwealth Need Not Show A Compelling State Interest to Take Actions Directly Related to the Purpose For Which Mental Patients Have Been Involuntarily Committed.

3/ The First Circuit failed to discuss the extent of the burden placed on the Commonwealth to justify its actions in forcibly medicating patients. Apparently, and without explanation, the First Circuit decided that the Commonwealth could not forcibly medicate patients unless its interests "outweighed" the patients' interests. See, Cert. App., p. 14a.

This Court has declared that constitutional rights of institutionalized persons are necessarily "subject to restrictions imposed by the nature of the regime to which they have been lawfully committed". Wolff v. McDonnell, 418 U.S. 539, 555 (1974). This Court has never directly addressed the question of what burden the state must meet to justify actions directly related to the purpose for which mental patients are committed. However, in the institutional context of a prison, this Court has declared that in the absence of substantial evidence to indicate that state officials have exaggerated their response to institutional objectives, courts should ordinarily defer to the state's expert judgment in such matters.[4/] Jones v.

4/ While the status of the mental patient is significantly different from that of a

(Footnote continued)

North Carolina Prisoner's Union, 433 U.S. 119, 128 (1977). This Court noted that an inmate does not retain those rights which are "inconsistent with his status as a prisoner or with the legitimate penological objectives of the corrections system". Id. at 129.

The logic of the Jones and Wolff opinions is equally applicable to the state hospital context. Involuntary mental patients, like prisoners, have lost their freedom pursuant to due process court hearings in furtherance of statutorily

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4/ (Footnote continued)

prisoner who has been convicted of a crime, see Vitek v. Jones, 445 U.S. 480, 493 (1980), this does not mean that the mental patient does not lose his rights inconsistent with his own status as an involuntary mental patient. This court has recognized that even the rights of persons not convicted of a crime are limited by the objectives and character of their institutionalization. See Bell v. Wolfish, 441 U.S. 520, 531-535 (1979) (The state need not show a compelling necessity to justify restrictions and privations of pre-trial detainees.)

prescribed societal goals. Involuntary mental patients, like prisoners, have been confined in state institutions. Psychiatric decisions, even more so than penological decisions, peculiarly require professional expertise. Thus, in the absence of substantial evidence to indicate that forcible medication is not necessary to meet the societal goal of treating involuntarily committed mental patients, this Court should defer to the Commonwealth's expert judgment in this matter.

a. Forcibly Medicating Patients With Antipsychotic Drugs Is Directly Related to the Purpose For Which Mental Patients in Massachusetts Are Committed.

1. Massachusetts Mental Patients are Committed for Care and Treatment.5/

5/ Whether involuntary mental patients have a constitutional right to treatment

(Footnote continued)

In Massachusetts, a mental patient can be committed only after a judicial determination that the individual is mentally ill and that failure to hospitalize him would create a likelihood of serious harm. Mass. Gen. Laws. c. 123, §§ 7, 8, Cert. App., pp. 188a-191a.

M.G.L. c. 123, § 4 makes it clear that the purpose of commitment is "care and treatment", as it provides that "any patient no longer in need of care as an inpatient shall be discharged . . ." J.A., pp. 204-205 (J-140-146).

Massachusetts Department of Mental Health Regulations § 221.03, entitled "Right to Treatment" provides:

Each patient admitted to a facility

5/ (Footnote continued)

is not an issue in this case. Massachusetts has legitimately exercised its parens patriae powers to afford such a right to treatment. This Court need not decide whether Massachusetts was constitutionally obligated to provide such a right.

> shall receive treatment suited to his needs . . . . Each patient shall receive such medical, vocational, social and rehabilitative services as his age, condition, and abilities require to bring about an early return to his community.

2. Antipsychotic Medications Are A Central Component of A Treatment Program for Major Mental Illness.

Psychotropic medication, and specifically antipsychotic medication, is essential to the treatment of major mental illness. As the First Circuit noted, "due in large part to the development of numerous drugs for treating mental illness, the possibility of improvement as a result of forced treatment is relatively substantial". Cert. App., p. 17a.

Testimony of two of the leading psychopharmocologists in the country indicated that for major mental illness, psychotropic drugs are a central component of a treatment program and are so considered by psychiatric programs around

the world. J.A., p. 206 (J-152). Psychopharmacotherapy is necessary for proper treatment of the vast majority of seriously disturbed patients and the vast majority of acutely ill mental patients. J.A., p. 206 (J-153).

About half of the available hospital beds for mentally ill and mentally retarded patients (and one-quarter of all available hospital beds) are occupied by schizophrenics. Berger, Hamburg and Hamburg, "Mental Health: Progress and Problems", 106 Daedalus 261 (1977); J.A., p. 207 (J-166). Both testimony and learned treatises introduced at trial concluded that antipsychotic drugs are now established as a necessary, if not always sufficient, component of any comprehensive treatment program for schizophrenia. J.A., p. 208 (J-167, 170, 172).

Moreover, withdrawal of antipsychotic medication when a patient refuses it can

cause severe relapse. J.A.. pp. 215-216 (J-212-214).

Even if, arguendo, other therapies were effective for treating psychosis, absent involuntary medication, the patient is likely to refuse all offered therapies. Testimony of two doctors indicated that mental patients refusing their antipsychotic medications frequently also refuse all offered treatment, physical examinations, and even contact with other people. J.A., p. 222 (J-258-260).[6/]

6/ Plaintiffs argue that, even if antipsychotic medications are essential to the treatment of major mental illness, these medications are not effective when administered forcibly. The First Circuit rejected this argument, Cert. App., p. 17a, and for good reason. Defendants solicited testimony of five different doctors (including two called by the plaintiffs) that involuntary medication can further cooperation with other treatments. J.A., pp. 221-222 (J-256-261). See also, "APA Position Statement on the Adequacy of Treatment", J.A., p. 201 (J-123) (To the same effect as above).

3. Involuntary Commitment Is A Sufficient Predicate For Forcibly Medicating Patients.

The First Circuit found that given the patient's constitutional right to refuse treatment, in order for the state to invoke its parens patriae interest as a justification to treat an involuntarily committed patient, in a non-emergency it must first obtain a judicial determination that the patient is incompetent. Cert. App., pp. 17a-18a, 30a. The First Circuit then concluded that under Massachusetts law there is no determination of incompetency at the time of commitment. Cert. App., pp. 18a-23a. The First Circuit failed to explain why incompetency (rather than the state's assumption of the decision making role at the time of commitment) is the factor relevant to whether a state can exercise its parens patriae powers through forcible medication.

Both the First Circuit and the

District Court fail to discuss the significance of the fact that involuntary patients are committed in Massachusetts only after a court finding beyond a reasonable doubt that they are so mentally ill as to justify taking away their freedom through commitment. Mass. Gen. Laws, c. 123, §§ 1, 7, 8, Cert. App., pp. 182a-185a, 188a-191a; Superintendant of Worcester State Hospital v. Hagberg, 374 Mass. 271, 372 N.E. 2d 242 (1978).[7/]

7/ The District Court below seriously misstated the law when it wrote that "[t]he patient is in an institution only because he is unable to function safely in society, and so there is a public interest in civil commitment." Cert. App., p. 91a. A patient cannot be committed solely because he cannot function safely in society; rather, a patient's condition must be found to (1) create a likelihood of serious harm, and (2) the patient must be found to be mentally ill. Mass. Gen. Laws, c. 123, § 8. The First Circuit, while noting that a patient must be mentally ill to be committed, does not discuss the significance of his mental illness, but rather focuses exclusively on the question of whether persons whose

(Footnote continued)

An understanding of mental illness, however, is critical in deciding whether a mental patient has a right to refuse treatment. In Massachusetts, a patient can be found mentally ill under c. 123 only when the person has a "substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life." Dept. of Mental Health Reg., § 200.01.[8/]

7/ (Footnote continued)

condition "create a likelihood of serious harm" are incompetent under the law. Cert. App., pp. 19a-21a.

8/ Berger, Hamburg and Hamburg note in their article "Mental Health: Progress and Problems", supra at 270, that in California, under a law similar to Massachusetts' law, persons found dangerous to themselves or others by reason of mental illness, in practice are suicidal or so schizophrenic that they are unable to care for their bodily needs. The authors further note that the two major illnesses

(Footnote continued)

A classic symptom of severe mental illness is ambivalence to treatment. J.A., p. 224 (J-245). It is hard to say that intramuscular medication is forcible because psychotic patients seem to want the staff to take over and to be firm about their treatments. J.A., pp. 224-225 (J-276-278). After a forceful stand is taken regarding medication, patients then usually take the medication voluntarily in the future. J.A., p. 225 (J-279). There is uncontroverted evidence from Drs.

8/ (Footnote continued)

(schizophrenia and manic psychosis) which are treated with antipsychotic medication are both disabling diseases. Id. at 262, 264. The one feature common to all manifestations of schizophrenic thought disorder is that the schizophrenic patient "thinks and reasons on his own autistic terms, according to his own intricate private rules of logic . . . . His thought processes are strange and do not lend to conclusions based on reality or universal logic." A. Freedman & H. Kaplan, Comprehensive Textbook of Psychiatry, 894-895 (2d Ed. 1976).

deMarneffe, Brill and Gill that many patients have thanked their doctor for not listening to them when they refused medication when they were sick, and not speaking their true mind. J.A., p. 225 (J-280-281). See, also, Berger, Hamburg, and Hamburg, supra at 271 ("Involuntarily treated schizophrenics are usually thankful when they are able to resume their former lives and relationships.")

Ignoring the nature of mental illness justifying commitment, the District Court and First Circuit have tied the right to forcibly medicate patients to the concept of incompetence, as if the Commonwealth were seeking to medicate forcibly perfectly healthy, competent individuals, who just happen to be living in mental hospitals. In fact, a determination of incompetency is particularly inappropriate as the trigger to justify forcibly medicating a patient. Competency to

determine one's need for psychiatric treatment can vary on a day-to-day basis. J.A., p. 266 (J-383, 384). In other words, a patient's symptoms frequently vary on a day-to-day basis affecting their competency. Thus, it makes no sense to have to seek a judicial declaration of incompetency to forcibly medicate a patient, when the same patient found judicially incompetent may act competently the day after the court determination.[9/]

On the other hand, it is logical to tie the right to medicate a patient forcibly to the mental illness which justified the patient's commitment.

9/ Plaintiffs, and the District Court, Cert. App., pp. 74a-75a, suggest that if not the Constitution, Massachusetts law ties forcible medication treatment to a determination of competency. The District Court placed heavy reliance on Mass. Gen. Laws. c. 123, § 25, which states:

> No person shall be deemed to be incompetent to manage his affairs, to

(Footnote continued)

The constant factor for a committed patient is his mental illness. In Massachusetts, when a patient is no longer in need of care for his mental illness, he must be released from the hospital. Mass. Gen. Laws c. 123, § 4. Whether or not the patient is competent on any given day is irrelevant to whether the patient can be committed or released and should be irrelevant to whether the patient can be treated.

9/ (Footnote continued)

> contract, to hold professional or occupational or vehicle operators licenses or to make a will solely by reason of his admission or commitment in any capacity to the treatment or care of the department or to any public or private facility, nor shall departmental regulations restrict such rights.
>
> M.G.L. c. 123, § 25 (emphasis added).

What is most significant about this statute is that it nowhere provides that a

(Footnote continued)

Involuntarily committed patients are considered so mentally ill that society has decided to override their failure to seek hospitalization voluntarily and their implicit, if not explicit, objection to being hospitalized for treatment. Given that these patients have already been

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9/ (Footnote continued)

patient should be deemed competent to make decisions as to his or her psychiatric treatment.

Moreover, G.L. c. 123, § 23 provides that a mentally ill patient shall have the right to refuse shock treatment and lobotomy, but fails to mention a right to refuse antipsychotic medication.

Department of Mental Health Regulation § 220.02 provides that a committed person shall receive treatment " including . . . intramuscular medication . . ." By regulation, only ECT and lobotomy require separate consent. Id.

Section 223.03 of the Department of Mental Health regulations provides that medication administered as part of a planned medical, psychotherapeutic program is not a restraint whose use is limited to emergency situations such as a serious threat of extreme violence, personal injury or attempted suicide.

recognized as so mentally ill that their decision to reject voluntary hospitalization and its treatment has been overridden, it is illogical to accept the patient's same objections to treatment once hospitalized. As the interest of the state is sufficiently important to deprive an individual of his physicial liberty, that interest is sufficiently important for the state to assume the treatment decision.

The First Circuit, in seeking to justify its opinion quotes the following language from an article entitled "Developments in the Law -- Civil Commitment of the Mentally Ill", 87 Harvard L. Rev. 1190, 1344 (1974):

> "Inherent in an adjudication that an individual should be committed under the state's parens patriae power is the decision that he can be forced to accept the treatments found to be in his best interest; . . .

Cert. App., pp. 16a-17a. It is difficult to understand how the First Circuit

interprets this language to do anything but contradict its own conclusion that the fact of commitment is insufficient justification for forcible treatment.

2. Patients Do Not Have a First Amendment Freedom of Speech Interest in Refusing Anti-psychotic Medication.

The District Court found that psychotropic drugs are mind altering.[10/] Cert. App., p 69a. The District Court therefore found that there is First Amendment protection against their use, as "whatever powers the Constitution has granted our government, involuntary mind control is not one of them . . . ." Cert. App., p. 91a. The District Court's conclusions are inaccurate as they ignore not only the nature of psychotic illness and medication

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10/ The First Circuit found it unnecessary, given the reasoning of their decision, to decide whether First Amendment rights were implicated in this case. Cert. App., p. 5a, n.2.

treatment but also as they expand the First Amendment far beyond its scope and purpose.

a. Antipsychotic Medications Are Mind Liberating, While Psychosis is Mind Controlling.

The District Court's finding that antipsychotic medication is mind controlling is one hundred and eighty degrees from the facts. Antipsychotic medications are mind liberating, while psychosis is mind controlling.

Psychotic thinking is not free thinking. While the symptoms of psychotic patients vary, patients are defined as psychotic only when their mental functioning is sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 2d ed. (1968) at 23. Acutely psychotic patients are terrorized and in a state of internal panic,

unbearable agony, pain and distress. J.A., p. 226 (J-288).

Antipsychotic drugs, on the other hand, liberate the mind control of psychosis. Antipsychotic drugs not only calm patients, but they interrupt and reduce psychotic thinking. J.A., p. 211 (J-181). Antipsychotic drugs cause a psychotic person's perception, J.A., p. 211 (J-186), cognition, id., learning ability, J.A., pp. 213-214 (J-197, 198), thought processes, J.A., pp. 211-212 (J-187), ability to handle abstractions, J.A., p. 214 (J-199), memory, J.A., p. 214 (J-200), initiative, J.A., p. 214 (J-201), socialization, J.A., pp. 214-215 (J-205), sponteneity, id., motivation, J.A., p. 215 (J-207), and attention to detail, J.A., p. 215 (J-210), to improve. See, als, J.A., p. 213 (J-195).

Tranquilizer is a misnomer for antipsychotic medication because it

implies clinical utility only in those patients who are excited and, therefore, require a calming effect. J.A., p. 213 (J-193). Withdrawn, apathetic patients tend to become more active and less apathetic when placed on antipsychotic medication therapy, while overactive patients tend to become less so.11/ J.A., pp. 212-213 (J-192A).

11/ In their article, "Rotting With Their Rights On: Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients", 7 Bull. Am. Acad. Psychiat. Law 308, 310, Drs. Applebaum and Gutheil conclude:

> In fact, properly used, psychotropic medications are chemically normative in their mechanism of action; that is, they restore existing imbalance toward the balanced norm. They are generally incapable of creating thoughts, views, ideas or opinions de novo, or of permanently inhibiting the process of thought generation. Thus, the psychotic conformist, cured of his psychosis with medications, remains the conformist; the depressed rebel, cured of his depression, remains the rebel still.
>
> (Footnote omitted.)

Antipsychotic drugs today are established and non-experimental. J.A., p. 207 (j-159). The efficacy of these drugs in treating acute and chronic schizophrenic patients has been established by a vast number of adequately designed and controlled studies conducted over the past twenty years, as well as by clinical practice.[12/] J.A., pp. 207, 209

12/ While plaintiffs attempted to contest the issue of the effectiveness of antipsychotic medications, the evidence was overwhelming that the medications work.

If there is any confusion regarding the effectiveness of antipsychotic medication, it may be caused because some respected doctors, such as Jonathan Cole (chief pharmacologist at McLean Hospital), have written that antipsychotic medications do not work for everyone. J.A., p. 117 (DR-111, 112). However, all the articles by respected authorities questioning the effectiveness of these medications deal with their effectiveness for chronic patients; there is no credible evidence questioning the effectiveness of these drugs for acutely psychotic patients. Moreover, even for chronic patients, it is recognized that while the medications do not help everyone, more

(Footnote continued)

(J-161-163, 177). Dr. Henry Brill, former President of the American College of Neuropsychopharmacology, testified that after reading thousands of articles on the subject, he has concluded that there are no articles which show there is not a general consensus as to the relative safety and effectiveness of antipsychotic medication, and, to his knowledge, there has never been a well designed study showing that antipsychotic drugs are not relatively safe and effective. J.A., p. 207 (J-161-162). Dr. Brill also testified

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12/ (Footnote continued)

patients on the medication are benefitted than patients off the medication, and as of this date, it cannot be predetermined which patients will benefit from the use of medication. J.A., pp. 215-216 (J-212-214); J.A., p. 93 (62[5]). See Jacobson v. Massachusetts, 197 U.S. 11, 37 (1905) (The state has the right to administer smallpox vaccinations involuntarily, even though it is impossible to determine with absolute certainty whether a particular person can be safely vaccinated).

that he was not aware of any leading clinical psychiatrist who believes that antipsychotic drugs are not relatively effective and safe. J.A., p. 207 (J-163).

b. There is No Fundamental First Amendment Right to Express Psychotic Thought.

The District Court concluded that the use of antipsychotic medication over a patient's objection violated his/her right to freedom of speech. The court cited to no precedent in support of this proposition. In fact, the court did not cite to a single first amendment case in its entire section on the first amendment. Cert. App., pp. 90a-92a. As a factual matter, the previous section of this Brief shows that antipsychotic drugs foster the free exercise of one's mind rather than impede or distort its use; given these facts, it is illogical to hold that the administration of these drugs violates First Amendment rights. The

illogic of the court's conclusion that antipsychotic drugs infringe on First Amendment rights merely because they are mind-altering in a favorable direction can be shown by analogy. Certainly, the use of medication to aid a patient to come out of a coma does not violate that patient's First Amendment rights. Yet, such medication clearly affects the brain and is mind-altering in the same sense as antipsychotic drugs; they both aid in restoring the brain to normal functioning. See, Chodoff, "The Case For Involuntary Hospitalization of the Mentally Ill", 183 Am. J. Psychiatry, 496, 501 (1976) (Freedom is not defined only by the absence of external constraints. Internal physiological or psychological processes can contribute to a throttling of the spirit that is as painful as any applied from the outside.)

3. The Refusal of Medication by an Institutionalized Patient is not Protected by a Fundamental Constitutional Right to Privacy Which Can Only Be Overcome by a Compelling State Interest.

The First Circuit declared that it was "intuitively obvious" that a person has a constitutionally protected interest in being left free to refuse antipsychotic medication, although "[t]he precise textual source of this interest is unclear". Cert. App., p. 4a. The First Circuit wrote that the source of the right was "most likely" a part of the penumbral right to privacy, bodily integrity or personal security. Cert. App., p. 5a. The First Circuit further incorrectly asserted that none of the parties contested the correctness of the above general proposition. Cert. App., p. 6a.

In fact, it is not surprising that the First Circuit had such difficulty in identifying a specific constitutional source for a right to refuse treatment,

because there is no precedent of this Court supporting such a right.[13/]

a. The Fundamental, Constitutional Interest in Protecting Peculiarly Personal Decisions Is Not Involved in this Case.

Roe v. Wade, 410 U.S. 113 (1973), remains the most thorough and authoritative exposition by this Court of that fundamental, constitutional right of privacy later characterized as "the interest in independence in making certain kinds of important decisions." Whalen v. Roe, 429 U.S. 589, 599-600 (1976). The Court in Roe v. Wade held that "only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty' . . . are included in

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13/ Even if the asserted "right to refuse treatment" was encompassed by the constitutional "right to privacy", a compelling state interest test should not be applied because of the institutional needs of treating involuntary patients. See Section IA1 of this Brief.

this guarantee of personal privacy." 410 U.S. at 152 (citations omitted).

The decisions surveyed in Roe v. Wade, 410 U.S. at 152-153, along with privacy decisions by this Court since 1973, make clear that the constitutional right of privacy clusters closely around the related concepts of marriage, procreation, contraception, family relationships, and child rearing and education. See, also, Paul v. Davis, 424 U.S. 693, 713 (1976); Carey v. Population Services International, 431 U.S. 677, 684-685 (1977). This Court has emphasized that it is the special sanctity traditionally accorded to home and family which confers constitutional protections upon these spheres. See, e.g., Griswold v. Connecticut, 381 U.S. 479, 484 (1965); see, also, Poe v. Ullman, 367 U.S. 497, 548-49 (1960) (Harlan, J., dissenting). This Court has further noted that "the protection of a

person's general right to privacy -- his right to be let alone by other people -- is, like the protection of his property and of his very life, left largely to the law of the individual States". Katz v. United States, 389 U.S. 347, 350-351 (1967). (Emphasis in Original.)

The right of involuntarily committed mental patients to refuse treatment is plainly not of the same order or type as the interests accorded protection by previous decisions of this Court. The fact that the patients involved in this case are all institutionalized is of primary importance. By definition, an institutionalized person under the care and supervision of the state no longer enjoys the privacy of a person living in his own home; what would be private decisions for a person living in his own home are inexplicably intertwined for the institutionalized person with the interests

of the state and other patients. Cf., Lanza v. State of New York, 370 U.S. 139, 143 (1962) (As a public jail is not the equivalent of a man's house, the Fourth Amendment does not protect conversations in the jail).

b. State-Initiated Bodily Intrusions Which Are Not "Brutal" or "Offensive" are Constitutional if Rationally Related to a Legitimate State Objective and Reasonable Under the Circumstances

As the right to privacy involved in this case is not the fundamental constitutional right to make certain personal decisions, the patients' right to privacy claim must rest on a right to be free from bodily intrusion by the government. However, as this Court noted in Jacobson v. Massachusetts, 197 U.S. 11, 31 (1905), the proper role for the judiciary in analyzing state impositions upon bodily integrity is not to examine the efficacy of the state's methods but

only to inquire whether or not those methods bear a "real and substantial relation" to legitimate state objectives. Only in radically more extreme cases, where the state's power was "exerted in such circumstances" as to be "arbitrary and oppressive" could any stricter form of scrutiny be invoked. 197 U.S. at 38.

In more recent Fourth and Fourteenth Amendment cases, this has held that bodily intrusions will be upheld if they are not "brutal", "offensive" or "shock the conscience". Rochin v. California, 342 U.S. 165, 172 (1952); Breithaupt v. Abram, 352 U.S. 432, 435 (1956); Schmerber v. California, 384 U.S. 757, 768 (1966). To apply strict judicial scrutiny to unconsented touchings which do not reach the threshold level of intrusiveness, outlined in Rochin, Breithaupt and Schmerber, would be to elevate what is at most a technical tort to the highest level

of constitutional protection.

c. The Potential Side Effects of Antipsychotic Drugs Do Not Render the Administration of these Drugs to be "Brutal", "Offensive", or "Oppressive".

Antipsychotic medications have a safety record commensurate with other powerful pharmacologic agents. Applebaum and Gutheil, supra. at 309. The benefits of antipsychotic medication far outweigh their costs.[14/] See, id.; J.A., p. 219

14/ The First Circuit in this case correctly concluded:

> [I]n many situations, despite the risks of harmful side effects, the administration of drugs to an individual is clearly in his best interests because of the beneficial effects that the drugs can have, including the amelioration of the patient's illness. In such situations, the failure to medicate an incompetent patient could have side effects -- e.g., the unnecessary and possibly irreversible continuation of his illness -- far more harmful, and probable, than any that might result from the drugs themselves.

Cert. App., p.27a. [Emphasis in Original].

(J-235); Gardos and Cole, "Overview: Public Health Issues in Tardive Dyskinesia", 137 Am. J. Psych., 776, 777 (1980); Jeste and Wyatt, "Changing Epidemiology of Tardive Dyskinesa: An Overview", 138 Am. J. Psych., 297, 306 (1981).

Most of the side effects of psychopharmacotherapy are minor. J.A., p. 219 (J-236). The District Court noted that all of the side effects it singled out except tardive dyskinesia are reversible. Cert. App., p. 71a. See, generally, J.A., pp. 219-221 (J-234-255) and pp. 108-116 (DR-92-109) for a discussion of the treatability and lack of severity of specific side effects.

The two side effects apparently of principal concern to the Distric Court were sedation and tardive dyskinesia. Cert. App., pp. 69a-70a, 87a. As for sedation, Applebaum and Gutheil note:

> As to control of behavior, it is true that a large enough dose of any drug that possesses sedating effects (including alcohol) will sedate a person; medications can be and have been used this way. It should be noted that most psychotropic drugs are relatively poor sedatives, however, and -- in keeping with their normative effect -- work predominantly on that excitement, agitation and assaultiveness that originates from the psychotic process itself.
>
> Applebaum and Gutheil, supra at 310-311.

Moreover, sedative effects of antipsychotic medication, while predictable during the early phases of administration, wear off and usually last no more than a couple of weeks. J.A., p. 93 (DR-62[1]).

Tardive dyskinesia is an involuntary movement disorder characterized by choreoathetoid movements, tics, grimaces and dystonia. Gardos and Cole, supra. at 776. Typically, tardive dyskinesia does not appear until after years of receiving antipsychotic medication. Jeste and Wyatt, supra. at 297; J.A., p. 83 (DR-24).

After the trial in this case, three overview articles have been published significantly updating the facts regarding tardive dyskinesia's proclivity, seriousness and treatability. Gardos and Cole, supra; Klawans, Goetz and Perlik, supra; and Jeste and Wyatt, supra. A compilation of all major studies now shows that the prevalence of persistent dyskinesia among hospitalized, chronically ill psychiatric patients being treated with antipsychotic drugs that may be attributable to antipsychotic medication is only 15%.15/ Jeste and Wyatt, supra at 304. Gradual reduction of dosage of antipsychotic medication, and treatment with reserpine, benzoquinotizine and choline, have all enjoyed some success in

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15/ This figure should be compared to the District Court's conclusion that two studies now place the prevalence of tardive dyskinesia among chronically, hospitalized schizophrenics at 50% to 60%. Cert. App., at 70a.

treating patients with tardive dyskinesia. Klawans, Goetz and Perlik, supra, at 904. A compilation of all recent major studies of treatments for tardive dyskinesia show that 41.7% of the 583 patients in the studies improved with treatment. Jeste & Wyatt, supra, at 303.

Gardos and Cole, noting the difference between incidence rates and prevalence rates of tardive dyskinesia, concluded that the risk for a schizophrenic inpatient being treated with antipsychotic drugs at McLean Hospital to develop tardive dyskinesia in any one year is only 4% - 5%. Gardos and Cole, supra at 776. Gardos and Cole further noted that most cases of tardive dyskinesia are mild cases. Id. at 777; see, also, J.A., p. 221 (J-254). In their own 12 year follow-up study of extensively drug-treated chronic, hospitalized schizophrenic patients, not a single case of

disabling tardive dyskinesia emerged in 89 cases.[16/] Id. Based on data collected in a survey of 20 experienced investigators of tardive dyskinesia, Gardos and Cole estimate that the prevalence of functional impairment persisting after drug withdrawal was less than 10% of the patients with dyskinesia. Id.

B. Defendants Have A Compelling State Interest in Forcibly Medicating Involuntary Patients.

While the Commonwealth need not show a compelling state interest in forcibly medicating involuntary mental patients (see previous secion of this Brief), the Commonwealth nevertheless has met even this heavy burden.

1. The Commonwealth Has A Compelling Interest In Being Able to Treat Those Patients Committed to its Hospitals.

16/ In this case, the District Court found that none of the seven named plaintiffs had contracted tardive dyskinesia. Cert. App., pp. 70a-71a.

a. The Character of the Patient Population at State Hospitals Justifies Forcible Treatment With Antipsychotic Medication

The First Circuit concluded that "[a]s a result of their afflictions, they [state hospital patients] are in many instances in desperate need of care and treatment . . ." Cert. App., p. 7a. This conclusion is amply supported by the record.

The uncontroverted evidence shows that patients at inpatient units of mental hospitals are very, very sick, disorganized people. They are psychiatrically, the equivalent of patients in the medical intensive care units.[17] See Defendants'

17/ State hospitals take patients during their most acute turmoil. Id., p. 356 (J-78). Approximately 40% of the patients at the Austin Unit at any one time were acutely psychotic. Id., p. 356 (J-81).

(Footnote continued)

Proposed Findings of Fact, p. 355, 356 (J-73-74, 74A, 78, 80).

In fact, the record shows that since Massachusetts changed its mental health laws in 1970 to require that a patient be a danger to himself or others to be involuntarily committed, the number of

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17/ (Footnote continued)

The First Circuit noted:

> [M]any individuals are involuntarily committed because of a demonstrated proclivity for committing acts of violence outside the hospital community, see Mass. Gen. Laws Ann. ch. 123, §§ 7, 8 and 1, a proclivity that the record shows often carries over after commitment. The volatility of a large concentration of such individuals adds substance and immediacy to the state's concern in preventing violence.

Cert. App., p. 11a.

See, also, J.A., p. 356 (J-83, 84) (Allowing one violent act to occur on a ward of psychotic patients frequently leads to general disruption or chaos).

(Footnote continued)

potentially violent patients admitted to the state hospitals has increased. See Defendants' Proposed Findings of Fact, p. 355 (J-76). See also, Id., pp. 355-356 (J-75-77).

b. The Commonwealth Has Traditional Parens Patriae and Police Power Interests in Caring for Its Mentally Ill Citizens.

The Commonwealth's interest in treating its involuntarily hospitalized

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17/ (Footnote continuned)

The District Court concluded that Dr. Gill testified that only 3% to 5% of the Austin Unit's patients engaged in violent behavior, and only 20% to 25% of that population were even potentially violent. In fact, Dr. Gill's exact testimony was that "there was a high percentage of patients who were potentially violent", that about 20-25 percent of the patients "would be easily triggered into a violent episode", and perhaps 3-5 percent of patients "actually engaged in violent behavior periodically". J.A., p. 53 (Emphasis added).

mental patients is founded both on its parens patriae and police powers. It is by treating her patients that the Commonwealth can reduce the danger the patient poses to himself or others. See the discussion in Section IVC of this Brief, rejecting the First Circuit's dichotomy that medication is sometimes given for parens patriae purposes and other times is given for police power purposes.

The parens patriae and police powers have long been found to be strong enough to justify essential medical procedures, such as the involuntary use of antipsychotic medication for the severely mentally ill. In Addington v. Texas, 441 U.S. 418, 99 S.Ct. 1804, 1809 (1979), this Court declared that the state has both an

interest under its police powers[18] to protect the community from the dangerous tendencies of some who are mentally ill, as well as a legitimate interest under its parens patriae powers[19] in providing care to its citizens who are unable because of emotional disorders to care for themselves.

2. The Commonwealth Has A Compelling State Interest in Preventing The Chronicity and Warehousing that Would Follow From Allowing Patients to Refuse Their Antipsychotic Medication.

a. Allowing Institutionalized Patients to Refuse Their Antipsychotic Medication Would Increase the Number of Patients Becoming Chronically Mentally Ill.

18/ In Jones v. North Carolina Prisoners' Union, 433 U.S. 119, 132-133 (1977), this Court held in the analogous prison context that the ever-present potential for violent confrontation justified reasonable steps to forestall such a threat, without waiting to the eve of the riot.

19/ In Mormon Church v. United States, 136 U.S. 1, 57 (1890) the Supreme Court described the "parens patriae" power as "inherent in the supreme power of every state . . . and often necessary to be exercised in the interest of humanity."

The District Court ruled that a patient could only be forcibly medicated when immediate action was necessary to prevent physical harm to a patient. Cert. App., p. 25a. The First Circuit ruled that forcible medication would also be appropriate in situations in which the immediate administration of drugs is reasonably believed to be necessary to prevent significant deterioration of the patient's mental health. It is not clear whether the First Circuit would require the commencement of a judicial competency hearing pending such emergency medication, and whether the First Circuit would allow the "competent" patient to refuse his medication even though it is needed to prevent further deterioration of the patient's mental health. Both the District Court opinion and the First Circuit opinion (if interpreted to permit only so much medication as to prevent

significant[20] deterioration pending a competency hearing, but not continued therapeutic doses of medication) would increase the number of patients becoming chronically mentally ill.

Uncontroverted evidence was introduced that the failure to medicate a psychotic patient with psychotropic drugs early in his illness invites chronicity. J.A., pp. 228, 216 (J-296, J-215-216). In fact, without psychotropic medication, schizophrenic patients have a high probability of chronicity developing. J.A., p. 208, 228 (J-171, 297).

b. Allowing Institutionalized Patients to Refuse Antipsychotic Medication Would Increase the Warehousing of These Patients.

20/ The requirement that any deterioration must be "significant" to justify forcible medication is bothersome. As serious mental illness slowly eats away at a person's mind and body, (see J.A., p. 118 [DR-115]), it is difficult to establish one point at which immediate medication is necessary to prevent significant deterioration or chronicity.

Patients are committed to Massachusetts state hospitals until they are treated. If the hospitals are then denied the power to treat the patient over his objections, our state hospitals will become, in fact, if not in name, caretaking facilities, more akin to correctional institutions than hospitals.

The District Court stated that "[t]here are alternative methods of treating mental patients, though some may be slower and less effective than psychotropic medication." Cert. App., pp. 98a, 99a. The District Court unfortunately ignored the reality of treatment of severe mental illness without psychotropic medication. One article graphically describes state hospitals before the introduction of psychotropic drugs when patients were treated with the "alternative, traditional" methods:

> Before drug therapies were introduced . . . state mental

> hospitals . . . were more likely to be custodial institutions than mental facilities . . . .
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> [S]chizophrenic patients with paranoid declusions crouched in corners in constant fear; catatonic patients were allowed to maintain the same rigid posture to the point of developing swollen legs and pressure sores; hallucinating patients paced the floor talking to their "voices" and unaware of what was going on around them. People sat year after year on benches or on the floor doing nothing, while their physical health deteriorated as well. Violent patients attacked staff members or other patients for reasons known only to themselves. . . .
>
> [N]either neurological diagnosis nor psychoanalytic psychotherapy had any substantial effect in the treatment of chronic schizophrenia or severe mania.
>
> Berger, Hamburg and Hamburg, supra at 262-263.
>
> See, also, J.A., p. 208 (J-170-172).

Allowing a patient to refuse medication will also have an umbrella effect increasing the number of patients relegated to warehoused status in our state hospitals. The failure to forcibly medicate an individual patient refusing medication would affect the entire milieu

of a hospital. J.A., pp. 222-223 (J-263). After the temporary restraining order in this case, one patient refusing medication frequently set off a sort of contagion of refusal. J.A., p. 222 (J-262).[21]

3. The Commonwealth Has A Compelling State Interest in Maintaining Acceptable Medical Standards.

As this Court noted in Roe v. Wade, 410 U.S. at 154, a State may properly assert important interests in maintaining medical standards.

Medical standards mandate treating institutionalized patients with antipsychotic drugs over their objections. The doctors in this case do not dispute that there are a few doctors who believe they can treat severely mentally ill

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21/ This same contagion of refusal was noticed by the court after Mr. Rennie was given the right to refuse treatment in the case of Rennie v. Klein, 462 F.Supp. 1131, 1152, n. 1 (D.N.J. 1978).

patients without drugs.[22] The existence of such a minority, however, cannot negate

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22/ The District Court placed considerable emphasis on its finding that the defendants and most of their expert witnesses testified that they would respect a patient's preference to refuse treatment, absent an emergency situation. Cert. App., p. 102a. This finding could not be more misleading. There is no resemblance between the defendants' and their experts' definition of an emergency and the District Court's definition of an emergency. The court limited forced medication to the same type of emergency posing a threat of violence that would justify the use of seclusion. Cert. App., pp. 84a-85a. The defendants and their experts defined an emergency as a situation in which a patient was acutely psychotic and in need of treatment. J.A., pp. 197-198 (J-97-107). At least three of the doctors who testified for the defendants stated outright that a situation which they were calling a "psychiatric emergency" and which would justify forcible medication would not necessarily pose a serious threat of personal injury or extreme violence to anyone. J.A., p. 194 (J-87); see, also, J.A., pp. 189-194 (J-86). At least five witnesses testified that patients had been forcibly medicated before the temporary restraining order in situations that would not have justified the use of seclusion. J.A., p. 195 (J-88). Not a single expert witness called by the defendants testified that they would respect a patient's

(Footnote continued)

the bottom line that there is apparently no major hospital today that attempts to treat major psychiatric illness without psychotropic drugs. J.A., p. 207 (J-157).

4. The Commonwealth Has A Compelling State Interest In Reducing State Hospital Populations.

22/ (Footnote continued)

refusal of medication, unless the situation constituted an emergency as defined by the District Court in its opinion. Four expert witnesses testified for the defendants that it was acceptable, if not obligatory medical practice, to forcibly medicate patients in some situations not necessarily posing a serious threat of personal injury. J.A., pp. 199-200 (J-109, 110, 114, 115, 118). One expert witness for the patients testified that it was proper to medicate incompetent patients when the doctor believes it is best for the patient, J.A., p. 199 (J-112, 113), while another two of the patients' experts wrote that drug therapy should be instituted without the patient's consent if the patient is acutely psychotic. J.A., p. 202 (J-125). One supervising doctor did testify that patients were not forcibly medicated except when they posed a serious threat of personal injury. J.A., pp. 50-52 (Kahn). However, this same doctor also noted that all involuntary patients by definition under law have been committed because of the likelihood of serious harm if they are not treated. J.A., p. 51.

The state has both a strong financial and moral interest in seeing that the number of patients hospitalized and the average stay of hospitalization decreases. The widespread use of antipsychotic agents has contributed greatly to the reduction of patients residenced in mental hospitals. J.A.. pp. 209, 216 (J-176, 217).

In fact, before the introducton of antipsychotic drugs, there never had been a time in the history of mental hospitals, which goes back for some 200 years, when there had been a reduction of population, despite efforts to do away with the hospitals, to close the hospitals, or to reduce their populations. J.A., p. 216 (J-218). However, when antipsychotic drugs were introduced, the increase of population stopped, the behavior in the hospitals improved and subsequently there has been a decrease of mental hospital

population of rather spectacular proportions. J.A., pp. 216-217 (J-219-222). Because of antipsychotic medication, community programs are now possible for many patients who previously required hospitalization. J.A., p. 217 (J-225). Furthermore, the widespread use of pharmacotherapeutic agents has also reduced the duration of hospitalization for patients at mental hospitals to a fraction of the previous duration. J.A., p. 217 (J-223, 224).

II. THE PROCEDURES FOLLOWED FOR FORCIBLY MEDICATING PATIENTS SATISFY THE REQUIREMENTS OF PROCEDURAL DUE PROCESS.

The First Circuit declared that a judicial declaration of incompetency was required before an involuntarily committed patient can be forcibly treated in a non-emergency. The trial court required the consent of a guardian before a patient

can be forcibly medicated.[23] Neither opinion discussed the procedures employed at the Austin and May Units prior to the court orders, nor did either opinion attempt to measure the adequacy of these procedures against the requirements of procedural due process that have been established by this Court.

In fact, the procedures employed at the Austin and May Units to medicate patients forcibly more than satisfy the requirements of procedural due process. Patients at both the Austin and May Units were only medicated, forcibly or otherwise, upon a doctor's order. J.A., p. 271 (K-207); Tr. 63 at 39. Each patient's medications at the Austin Unit

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23/ The First Circuit, on the other hand, concluded that "the nature of the problem presented is such that it is unwise to declare that the Constitution requires that state officials must receive guardian approval for individual treatment decisions simply because the administration of drugs is recommended." Cert. App., p. 28a.

were reviewed regularly on an ongoing basis by the entire staff in rounds, team meetings, staff meetings, meeting with patients and on an impromptu basis whenever an issue surrounding a patient's medication arose. J.A., pp. 270-271 (K-196, 199). If a patient at the Austin Unit was refusing regular medication on a regular basis, that fact would be reported to his or her physician. J.A., p. 271 (K-200). Doctors at the Austin Unit were notified if a patient was actually forcibly medicated. J.A., p. 271 (K-201).

At the May Unit, team meetings of staff and patients were held on each ward twice a week, and the details of the side effects of drugs were reviewed at these meetings. J.A., p. 271 (K-202, 203). The circumstances under which a physician's order authorizing involuntary medication of a patient was to be instituted were reviewed by the physician with the staff.

J.A., p. 271 (K-204). It was the policy at the May Unit that the physicians were to be notified when a patient refused medication. J.A., p. 271 (K-205). If a patient were in fact involuntarily medicated, a doctor would know about it. J.A., p. 271 (K-206, 208).[24/]

A. The Austin and May Unit Procedures For Forcibly Medicating Patients Satisfy the Requirements of Due Process of Law.

Even if, arguendo, constitutionally protected interests are implicated in the decision to forcibly medicate, the procedures employed were constitutionally sufficient.

"Due process is flexible and calls for such procedural protection as the parti-

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24/ A pamphlet entitled "Your Rights" which was handed out to patients upon admission indicated that a patient's decision to refuse treatment could only be overridden for good cause subject to the review of the supreintendent. J.A., pp. 36-37.

cular situation demands." Morrissey v. Brewer, 408 U.S. 471, 481 (1972); see Cafeteria and Restaurant Workers v. McElroy, 367 U.S. 886, 895 (1961). This Court in Matthews v. Eldridge, 424 U.S. 319 (1976), indicated that the specific dictates of due process generally requires consideration of three distinct factors:

> First, the private interest that will be affected . . .; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the functon involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.
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> 424 U.S. 319, 335 (1976).

1. At Best, The Patient's Private Interest in Refusing Medication Is Contradictory.

While it may be in a patient's interest to participate in treatment decisions when possible, it is in the ultimate interest of the committed patient to receive necessary care and treatment.

Furthermore, mandated judicial competency hearings[25] and appointment of guard-

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25/ Delays are inherent to judicial proceedings to determine competency J.A., pp. 265, 266 (J-378-380, 386). It takes a certain amount of time to find a guardian. Patients are given certain rights of notice which necessarily take time. A contested case is faced with the normal delays of discovery and a contested hearing. The length of this trial must certainly give pause to any requirement to hold a hearing to determine whether a patient is incompetent and whether it is in the patient's best interests to be forcibly medicated.

Both the District Court and the First Circuit note that defendants concede that there is statutory authority for "immediate appointment" of temporary guardians in emergency situations. Cert. App., p. 79a, n. 15, 24a. This is of no relevance because if an emergency existed justifying the appointment of a temporary guardian, the same emergency would justify the imposition of medication on the patient without the need for seeking a guardian.

Any time delay is significant in light of the potential deterioration of the patient and the need to treat psychotic patients as soon as possible J.A., p. 228 (J-299). Time delays are also significant given the large potential for escape while a guardian's help is being sought. J.A., p. 265 (J-381).

ians[26/] are also contrary to the patient's private interests.

2. The Commonwealth Has A Strong Interest in Forcibly Medicating Patients Without Being Burdened With Additional Procedures.

On the other hand, the Commonwealth has a substantial interest in avoiding unnecessary judicial proceedings which

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26/ Guardians are frequently found to be antitherapeutic, see, generally, J.A., pp. 265-267, (J-378-392), by exercising too personal an interest in the patient, J.A., pp. 266-267 (J-390), and because of their absence when treatment decisions need to be made. J.A., p. 267 (J-392). Gutheil, Shapiro, and St. Clair in their article "Legal Guardianship in Drug Refusal: An Illusory Solution", note that from the patient's perspective, the imposition of a guardian may well be perceived as a greater restriction than the imposition of medication. 137 Am. J. Psych. 347, 349 (1980). Gutheil, Shapiro and St. Clair also note the negative effect on the therapeutic alliance of both requiring the treating physician to go to court to declare his patient incompetent and of bypassing the patient in favor of the guardian for making non-medication and non-treatment decisions. Id. See, Parham v. J.R., 442 U.S. 584, 605, 610 (1979), discussing the constitutional relevance of avoiding judicial proceedings which will create an adversarial relationship between the caretaker and the patient.

carry the potential of preventing the Commonwealth from providing involuntary patients at its hospitals the care and treatment, consistent with standards of medical practice, that it deems necessary.

Shifting the ultimate decision whether to medicate a patient onto a guardian is particularly inappropriate. A guardian is charged with protecting the interests of his ward, and his ward alone. As the decision of one patient to refuse medication, however, necessarily affects other patients, this is the type of decision which must remain with the Commonwealth, the only party charged with protecting the interests of all the patients and staff at its state hospitals.

Moreover, the costs of requiring judicial competency hearings, both in monetary terms[27/] and in terms of manpower

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27/ See Gutheil, Shapiro and St. Clair, supra at 350.

displacement,[28] are considerable.

3. There Is Little Value In Providing Additional Procedural Safeguards.

Finally, there would be little value in requiring additional procedural safeguards. This Court has recognized the reliability, for due process purposes, of "routine, standard and unbiased medical reports by physician specialists." Matthews v. Eldridge, 424 U.S. at 344, quoting Richardson v. Parales, 402 U.S. 389, 404 (1971). Moreover, given the variable nature of competency, it is difficult to understand whether the District

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28/ As this Court noted in Parham v. J.R., 442 U.S. at 605,

> One factor that must be considered is the utilization of the time of psychiatrists, psychologists and other behavioral specialists in preparing for and participating in hearings rather than performing the task for which their special training has fitted them.

Court and the First Circuit sought to require the Commonwealth to go into court potentially two or three times a week, whenever the patient's apparent competency to understand his treatment improved or worsened.

Additional procedural safeguards would also interfere with the physician's need to make a basically medical decision of whether a patient because of his mental illness requires forcible medication treatment. As this Court noted in Parham v. J.R.:

> The judicial model of fact finding for all constitutionally protected interests, regardless of their nature, can turn rational decisionmaking into an unmanageable enterprise[29] . . .
>
> The mode and procedure of medical diagnostic procedures is not the business of judges . . . .

29/ It is difficult to reconcile this language from Parham with the unsupported assertion of the First Circuit that "judicial determinations are certainly preferable in general . . ." Cert. App., p. 25A.

> Even after a hearing, the non-specialist decision-maker must make a medical-psychiatric decision . . . 442 U.S. at 608, n. 16, 609.

The availability of other procedures to remedy abuses also dictates against the provision of additional procedural safeguards everytime a physician wishes to medicate a patient forcibly for treatment purposes. If a person not in need of treatment is wrongly treated in a hospital, the remedy is through an individual action, challenging the propriety of the treatment or hospitalization, and, if appropriate, seeking monetary damages. O'Connor v. Donaldson, 422 U.S. 563 (1975).[30/]

30/ See, also, Ingraham v. Wright, 430 U.S. 651, 679, n. 47 (1977) ("[P]rior hearings might well be dispensed with in many circumstances in which the state's conduct, if not adequately justified, would constitute a common law tort."); Doe v. Bolton, 410 U.S. 179, 199, 200 (1973) (Required acquiescence by co-practitioners unduly infringes on a physician's right to practice; if a physician fails, he is subject to professional censure and deprivation of license).

The absence in the record of instances of past abuse is also indicative of the lack of a need for additional procedural safeguards. While the District Court found that in some instances patients were forcibly medicated in non-emergencies, it apparently also found that such instances were limited to situations where medication was administered as part of a psychotherapeutic program. Cert. App., pp. 123a-124a, 117a-118a. The First Circuit upheld the District Court's findings that defendants had acted in what they believed to be the best interests of the patients and they had acted non-negligently. Cert. App., pp. 32a, 37a. See, Matthews v. Eldridge, 424 U.S. 319, 344 (1976) ("[P]rocedural due process rules are shaped by the risk of error inherent in the truthfinding process as applied to the generality of cases, not the rare exceptions . . ."); Jacobson v.

Massachusetts, 197 U.S. 11, 38 (1905) (Extreme cases can be readily suggested. Ordinarily such cases are not safe guides in the administration of the law.)

In certain respects, this case is not one of first impression. In Vitek v. Jones, 445 U.S. 480, 494 (1980), this Court established the minimum procedures necessary for transferring a prisoner to a mental hospital for a "mandatory" treatment program. This Court declared that the State was required to provide the following minimum procedures: (1) Written, timely notice, (2) a hearing before an independent decision-maker, (3) the right to present testimony except upon a showing of good cause, (4) a written finding, and (5) competent assistance provided by the state if necessary. 445 U.S. at 494, 495, 497.[31/]

31/ Also relevant is the case of Ingraham v. Wright, 430 U.S. at 682, which held

(Footnote continued)

In Massachusetts, before a patient is committed for involuntary treatment, he is afforded all of the above procedures and more. Mass. Gen. Laws c. 123, §§ 5, 7, 8, 9. Cert. App., pp. 188a-191a Appendix to Petitioner's Brief, pp. A1-A5.

III. PLAINTIFFS DO NOT HAVE A CONSTITUTIONAL RIGHT TO BE TREATED WITH LESS RESTRICTIVE ALTERNATIVES THAN FORCIBLE MEDICATION.

The First Circuit declared that a decision to forcibly medicate a patient demands an appraisal of alternative, less restrictive courses of action. Cert. App., p. 12a. The First Circuit concluded that "reasonable alternatives to the administration of antipsychotics must be

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31/ (Footnote continued)

that no additional procedural safeguards were necessary in a situation characterized by (1) a low incidence of past abuse, (2) the availability of common law safeguards, and (3) decisions peculiarly within the realm of another profession's responsibility.

ruled out." Id., p. 14a. The First Circuit offers no precedent or constitutional analysis supporting its declaration of the existence of a right to be treated by the least restrictive alternative.

In Sanchez v. New Mexico, 396 U.S. 276 (1970), this court dismissed, for want of a substantial federal question, an appeal taken from the New Mexico Supreme Court's decision in State v. Sanchez, 80 N.M. 438, 457 P.2d 370 (1960) that the least restrictive alternative doctrine did not apply to civil commitment proceedings. See Pennhurst State School and Hospital v. Halderman, 49 L.W. 4363, 4367, n. 12, ___ U.S. ___ (1981), apparently reaffirming Sanchez.

A. This Court Has Never Recognized an Independent 'Right' to Receive the Least Restrictive Alternative Government Action, But Has Used the Doctrine as a Test for Legislation which Infringes Fundamental Rights.

Since its inception the least restrictive means test has been an adjunct to judicial strict scrutiny, employed to ensure a precise means-end fit when legislation encroached upon preferred first amendment rights. See Shelton v. Tucker, 364 U.S. 479, 498 (1960). Although "particularly important to the free speech area," the test has occasionally "been applied in non-speech areas, such as state regulation affecting interstate commerce." J. Nowak, R. Rotunda, J. Young, Handbook on Constitutional Law (1978) at 727. But even when cast loose from its first amendement roots, the function of the least restrictive alternative test has remained constant: it is a mode of inquiry into the constitutionality of legislation, and not into the propriety of individual acts.

B. The Application of the Least Restrictive Means Test to Individual Treatment Decisions by Physicians Would Produce a Harmful and Senseless Result.

To subject every decision to medicate a patient to the least restrictive means test would harm patients by forcing physicians to concentrate on the wrong questions. Rather than asking, in each instance, what treatment would most benefit the individual patient, the doctor would have to ask himself what treatment would be viewed by a judge as the least restrictive appropriate treatment. Such deliberations would inevitably militate in favor of the least possible treatment, short of total neglect. Moreover, as now Chief Justice Burger observed in dissent in Lake v. Cameron, 364 F.2d 657, 663 (Burger, J., dissenting), the extension of the least restrictive alternative test even to initial civil commitment hearings would require a "District Court to perform

functions normally reserved to social agencies by commanding search for judicially approved course of treatment or custodial care for [a] mentally ill person."

IV. EVEN IF INVOLUNTARY PATIENTS HAVE A RIGHT TO REFUSE TREATMENT, THE COMMONWEALTH HAS A COMPELLING STATE INTEREST IN BEING ABLE TO FORCIBLY MEDICATE IN SITUATIONS OTHER THAN (1) WHERE A DOCTOR BELIEVES IN HIS PROFESSIONAL JUDGMENT THAT THE MEDICATION IS NECESSARY TO PREVENT VIOLENCE, AND (2) WHERE ANY DELAY COULD RESULT IN SIGNIFICANT DETERIORATION OF THE PATIENT'S MENTAL HEALTH.

The First Circuit recognized two emergency exceptions to its ruling that patients cannot be forcibly medicated absent an incompetency hearing: (1) where a doctor believes in his professional judgment that the medication is necessary to prevent violence, Cert. App., pp. 7a-15a, and (2) where any delay could result in significant deterioration of the patient's mental health. Cert. App., pp. 24a-26a. Even if, arguendo, there is a

constitutional right to refuse treatment, this Court should recognize exceptions greater than those recognized by the First Circuit.

A. The Commonwealth Has A Compelling State Interest in Preventing Unnecessary Severe Psychic Suffering

Psychotic patients, whether or not dangerous or incompetent, suffer severely, are terrorized by their illness and are in a state of internal panic, unbearable agony, pain and distress.[32/] J.A., p. 226 (J-285-288). Thus, the failure to forcibly medicate patients who are acutely psychotic, even if they are not in danger

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32/ Applebaum and Gutheil note that in their study of patients refusing antipsychotic medication, the one suicide was a patient, suffering narcissistic injury from his psychosis, who spent an unconscionably long time in an acute psychotic state because of delays in judicial and departmental procedures in obtaining a guardian. Applebaum and Gutheil, supra at 723.

of significantly deteriorating, creates unnecessary pain and panic for the patients. J.A., p. 226 (J-283, 284). The First Circuit failed to explain why the Constitution requires this "pain and panic" for a "competent" person so mentally ill as to be committed or an "incompetent" committed person pending a competency hearing.[33/]

B. The Commonwealth Has A Compelling State Interest in Preventing the Increase in Violence That Will Likely Follow the First Circuit's Order.

The First Circuit accepted defendants' argument that forcible medications could not be limited to situations posing a probability of violence. Nevertheless, the First Circuit, tieing its opinion to ostensibly clear cut legal distinctions, established a system difficult, if not

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33/ The First Circuit did acknowledge that individuals afflicted with mental illness often are confronted with severe suffering. Cert. App., p. 17a.

impossible, to administer in practice,[34/] and likely to lead to an increase in violence at our state hospitals. The First Circuit would allow certain patients to be forcibly medicated pursuant to police powers to prevent violence, and other patients to be forcibly medicated pursuant to parens patriae powers to prevent a patient's severe deterioration. The problem is that the doctor at the hospital who wishes to treat a patient, who may or may not be potentially violent, does not ask himself if he can exercise his police or parens patriae powers; rather, he asks himself whether the proper medical response to the

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34/ It is difficult to reconcile the First Circuit's opinion that medication can only follow a doctor's determination that it is needed to prevent violence, Cert. App., p. 14a, with the same court's recognition that "the array of relevant factors bearing on a quantitative judgment [of likelihood of violence] in this institutional setting almost defies prediction or reviewability." Cert. App., p. 13a.

patient's illness is antipsychotic medication.

The record shows that all acutely psychotic patients have the potential for impulsively committing a dangerous act. J.A., pp. 228-229 (J-299-302). Even with no history of violence, the patient's irrational thought processes might lead to the commission of a violent act.[35/] Moreover, there is no way to predict how one psychotic patient is going to react to the unpredictable acts of another patient.[36/] Given this potential for im-

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35/ The case history of J.T. is instructive. Although he had no history of violence before the temporary restraining order was issued in this case, when he was allowed to refuse medication and remain floridly psychotic, he attacked an attendant, fracturing his face so badly that the attendant required surgery. J.A., pp. 235, 243 (J-335, 355).

36/ The case history of J.R. is instructive. When forcibly medicated before the temporary restraining order,

(Footnote continued)

pulsive violence, the failure to medicate a patient forcibly increases the chances of such an impulsive act being committed. Moreover, psychiatric diagnosis is based upon medical impressions, making it very difficult to offer definite conclusions about any particular patient. Addington v. Texas, 441 U.S. 418, 430 (1979). The First Circuit's opinion is flawed by its failure to acknowledge the general need to treat state hospital patients to alleviate their illnesses, which in and of themselves are time bombs to violence.

36/ (Footnote continued)

she used to require only four to six weeks of hospitalization before being discharged; after the temporary restraining order, she refused her medication and remained in the hospital for six months in an acutely psychotic, delusional state (believing she was a man), until she was severely beaten by a male patient whose clothing she had stolen and was wearing. J.A., p. 240 (J-349).

V. EVEN IF INSTITUTIONALIZED MENTAL PATIENTS HAVE A CONSTITUTIONAL RIGHT TO REFUSE TREATMENT, THE COMMONWEALTH HAS A COMPELLING STATE INTEREST IN BEING ABLE TO FORCIBLY MEDICATE THESE PATIENTS WITH ANTIPSYCHOTIC DRUGS IN SITUATIONS OTHER THAN THOSE RESULTING IN OR WHICH POSE A SUBSTANTIAL LIKELIHOOD OF EXTREME VIOLENCE, PERSONAL INJURY OR ATTEMPTED SUICIDE.

The District Court has interpreted the First Circuit's opinion as upholding its original order. Cert. App., pp. 176a-178a. The District Court's permanent injunction in this case was virtually identical to the temporary restraining order issued in this case on April 30, 1975 and remaining in effect through the conclusion of the trial approximately three and one-half years later. The lower court prohibited the forcible medication of a patient except in an emergency which would justify the use of restraints such as seclusion.[37/] This is a serious

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37/ The District Court noted the many alternative definitions of psychiatric

(Footnote continued)

error. While restraints should be used as little as possible, treatment should not be so limited. See J.A., p. 268 (J-399).

A. The History of the Austin and May Units After The Temporary Restraining Order in this Case Supports the Commonwealth's Contention That There Is A Compelling State Interest in Forcibly Medicating Patients in Situtions Other Than Those Resulting In or Which Pose A Substantial Likelihood of Extreme Violence, Personal Injury or Attempted Suicide.

37/ (Footnote continued)

emergency offered by the Commonwealth at trial and concluded that the Commonwealth seeks a definition of a psychiatric emergency so broad as to encompass all the suggested definitions. Cert. App., pp. 83a-85a. The different definitions were offered as alternatives, from which the court would hopefully draw its own realistic definition of a psychiatric emergency. Rather than synthesizing the many different definitions, the District Court decided to ignore all of them. The Commonwealth suggests that the two definitions which best synthesize the elements of the others are the one offered by Dr. Gill (A psychiatric emergency is a situation when a patient requires the prompt initiation of medication treatment to prevent further severe suffering by that patient or the rapid worsening of that person's clinical state), J.A., p.

(Footnote continued)

The history of the hospitals having to honor a patient's "right to refuse treatment", as created by the District Court's temporary restraining order, supports the Commonwealth's contention that there is a compelling state interest in forcibly medicating patients.

Despite literally days of testimony regarding the effects of the temporary restraining order, the lower court attempted to relate the experience under its order in two sentences. The court stated in full:

> Although Dr. Gill expressed concern as to the impact of the TRO on effective treatment, he could identify only 12 patients out of 1,000 who refused their medication for prolonged periods

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37/ (Footnote continued)

267 (J-394) and the one offered by Dr. Frazier (A psychiatric emergency is any urgent psychiatric condition, functional or organic, for which immediate treatment would increase or contribute to the patient's likelihood of recovery, or provide urgently needed protection). J.A., p. 197 (J-100).

between May 1, 1975 and June 23, 1977 -- and most of those changed their minds within a few days. None of these patients was transferred to a more secure institutional setting because of behavioral problems.[38] Cert. App., p. 98a-99a.

This finding is completely inadequate, taking out-of-context the answer of one doctor to one question of one set of interrogatories,[39] while ignoring days

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38/ In a footnote, the court concluded that "[i]n at least one instance of violence by a patient who refused treatment, Dr. Gill acknowledged at trial that the signs of likely physical harm, absent forced medication, were present and the consequences predictable. Forced medication would, therefore, have been permissible under the provisions of the TRO." Cert. App., p. 98a-99a. The First Circuit rejected this finding of the District Court. Cert. App., pp. 9a-10a. See, also, J.A., pp. 53-70, describing the history of this patient after the temporary restraining order. The first circuit implicitly seems to have rejected all of the District Court's findings regarding the effects of the temporary restraining order. Cert. App., pp. 9a-10a.

39/ It is true that Dr. Gill, the in-patient director of the Austin Unit, cited to only twelve patients in an interrogatory question asking him to de-

(Footnote continued)

of testimony of the same doctor as well as the testimony of many other witnesses. In fact, five different witnesses testified of patients suffering from the effects of the temporary restraining order. See Whiters v. State of Georgia, 385 U.S. 545,

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39/ (Footnote continued)

scribe those patients who had suffered from the temporary restraining order's ban on forcible medication. Dr. Gill's Answer to Question #14, Interrogatory III. J.A., pp. 39-47. This answer was provided pursuant to an agreement between counsel whereby the defendant Gill was not required to answer all twenty-one parts of the interrogatory question and was only required to relate the histories of those patients he could remember at the time without reviewing the records of all patients at the Austin Unit.

It is significant to note that at the time Dr. Gill answered the questions in the Third Set of Interrogatories, he had not reviewed a list of all patient admissions, discussing that list with other staff to jog his memory as to who had been negatively impacted by the temporary restraining order. At the time of his testimony, he had done so. J.A., p. 274. Based upon this more comprehensive review, Dr. Gill testified that he was able to recall (1) eighty-nine patients

(Footnote continued)

550 (1967) (Where constitutional issues are involved, this Court may make an independent examination of the facts.)

The evidence presented by these witnesses demonstrated that the temporary restraining order had a deleterious effect upon patient care, creating increased tension, violence, patient suffering and

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39/ (Footnote continued)

at the Austin Unit who refused antipsychotic medication between May 1, 1975, through the summer of 1977, J.A., p. 235 (J-331), (2) fourteen patients who had previously been admitted to the Austin Unit who were denied admission because they were known to have refused treatment after the temporary restraining order and it was believed they could not be adequately cared for under the temporary restraining order, J.A., p. 237 (J-339), and (3) fifty-six patients at the Austin Unit who refused medication and had their hospitalization prolonged, although they did not suffer serious physical or mental consequences as the result of their refusal. J.A., p. 239 (J-346). The patients' counsel were provided with the records of the eighty-nine patients Dr. Gill testified suffered serious consequences from their refusal of medication. The patients' counsel challenged Dr. Gill's conclusion for only seven of these eighty-nine patients.

deterioration. See, generally, J.A., pp. 233-247 (J-319-377).

Moreover, the temporary restraining order negatively affected ward milieu and interfered with treatment relationships between patients and staff. J.A., pp. 243-245 (J-356-366). Patients tested the staffs' commitment to them by refusing medication, and in their own diseased minds found that commitment wanting when staff could not take firm measures. J.A., pp. 244-245 (J-360-365).

Following the temporary restraining order, there was an increase in the number of patients who needed to be transferred to Bridgewater State Hospital, a maximum security facility. J.A., pp. 245-246 (J-367-370). Moreover, the need to seclude patients after the temporary restraining order increased.[40/] See, Monthly Reports

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40/ For the ten months preceding the TRO, (Footnote continued)

of Restraint and Seclusion appended to Defendant Michael Gill's Answers to Plaintiffs' Third Set of Interrogatories for the raw data regarding seclusions at the Austin Unit.

Finally, the temporary restraining order had a negative effect on the staffing of the Austin and May Units. J.A., pp. 246-247 (J-371-375). Staff turnover at the Austin Unit approximately doubled after the restraining order. J.A., p. 246 (J-371). The issuance of the restraining order contributed to the loss

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40/ (Footnote continued)

for which there are records, patients at the Austin Unit were secluded an average of 525 hours per month. For the twenty-two months following the TRO, patients had to be secluded an average of 871 hours per month.

The Austin Unit's experience is consistent with one study that showed that after the introduction of psychotropic medications in 1955, the use of restraints and seclusion dropped by approximately ninety per cent. Tr. 57 at 44.

of the psychiatric residency program at the May Unit's successor unit, when it was concluded that the inpatient service was too dangerous for a single resident to be assigned to a ward. J.A., p. 247 (J-375). Some staff left, unable to watch patients deteriorate who could have been treated with medication. J.A., p. 246 (J-373).[41/]

It is of considerable significance that while the Commonwealth presented much evidence of the negative effects of the temporary restraining order, the patients did not present any evidence whatsoever of anyone who benefitted from the order during the three and one half years it had been

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41/ The Commonwealth presented detailed case studies of fifteen different patients as examples of the kind of suffering that followed the District Court's temporary restraining order. The total inadequacy of the District Court's findings is reflected in the fact that it failed to discuss even one of these histories. For more complete details of these and other case histories, see, J.A., pp. 235-237, 237-238, 238-239, 240-243, 245 (J-334-338, 340A-341, 343-345, 348-355, 366).

in effect. Nor did the patients even call a single witness to testify who disagreed with the Commonwealth's appraisal of the disastrous effects of the court's order.

Alan Stone, professor at Harvard Law School and former President of the American Psychiatric Association, commenting on the Rogers case, sums up, by stating:

> This scenario [at the Austin and May Units after the temporary restraining order] has developed despite the fact that the patient census in this hospital is very small by state hospital standards and the staff is far above average in quality . . . As one reads this description, [of the Units] one can only conclude that the courts are unwittingly reversing 200 years of progress and transforming the twentieth century dream of the mental health center into the eighteenth century nightmare of Bedlam. Stone, "Recent Mental Health Litigation: A Critical Perspective," 134 Am. J. of Psych. 273, 278 (1977).

VI. EVEN IF THE FIRST CIRCUIT CORRECTLY DELINEATED THE SCOPE OF A CONSTITUTIONAL RIGHT TO REFUSE TREATMENT, ITS REMAND VIOLATED PRINCIPLES OF FEDERALISM.

The First Circuit found that the record supported the trial court's findings that

(1) defendants had acted in subjective good faith, (2) defendants had not violated clearly established constitutional rights, and (3) defendants had not acted negligently. Cert. App., pp. 32a-33a, 37a. Yet, despite these findings of no deliberately wrongful or even negligent behavior, the First Circuit has not left to the defendants the power to promulgate their own regulations consistent with the substantive law as declared in the First Circuit opinion.

The First Circuit noted only two constitutional procedural requirements for forcibly medicating patients; they described these constitutional requirements as minimum requirements of due process. Cert. App., pp. 14a; 29a. Nevertheless, the First Circuit remanded the case to the trial court with instructions "to be creative in designing procedural mechanisms" which apparently

could have exceeded these minimum constitutional requirements. Cert. App., pp. 14a-15a. In remanding the case, the First Circuit ignored the dictates of this Court to limit unnecessary interference with state executive agencies and to limit injunctions to those situations where a federal court's intervention is necessary to secure protection of federal rights.

In Rizzo v. Goode, 423 U.S. 362, 378 (1976), this Court declared that considerations of federalism dictate against federal courts fashioning prophylactic procedures for state agencies.

Similarly, in Bell v. Wolfish, 441 U.S. 520, 561 (1979), this Court declared that under the Constitution, the first question to be answered is not whether a court's plan is better than the Executive's plan, but in what branch of the Government is lodged the authority to initially devise the plan. The First

Circuit in this case, in remanding the case to the District Court for the design of creative procedural mechanisms, clearly has failed to ask the proper question of which branch of government has the initial responsibility for devising plans to comply with constitutional rulings. See, also, Pennhurst State School and Hospital v. Haldeman, 49 L.W. 4363, 4377, ___ U.S. ___ (1981) (Blackmun, J., concurring) (A Court should announce what it believes is necessary to comply with an act, and give the State appropriate time to decide how to comply.)

The remand in this case is particularly inappropriate given the findings that defendants acted non-neglently, in subjective good faith, and did not violate any clearly established consitutional rights. As this Court noted in Rizzo v. Goode, 423 U.S. at 378, "the nature of the violation determines the scope of the

remedy".[42/] In Parham v. J.R., 442 U.S. 584, 615-616 (1979), this Court noted the relevance of defendants having acted in good faith in declaring that no new procedures need be ordered by the Court. Yet, in this case despite the lack of a finding of any active wrongdoing on the part of the defendants, the state officials find themselves facing ongoing federal supervision of their actions, and the loss of flexibility resulting from the need to go to court to make any changes in procedures which would be ordered by the District Court.

42/ See, also, Douglas v. Jeannette, 319 U.S. 157, 165 (1943), where this Court stated:

> . . . [A]n injunction looks to the future . . . [W]e find no ground for supposing that the intervention of a federal court, in order to secure petitioner's constitutional rights, will be either necessary or appropriate.

[Citations Omitted].

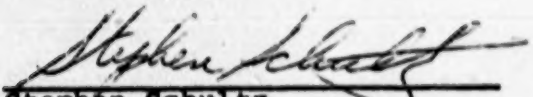
CONCLUSION

For the reasons stated in this Brief, this Court should declare that involuntarily committed mental patients do not have a right to refuse treatment with antipsychotic medication. If this Court were to find that involuntarily committed mental patients have a right to refuse treatment with antipsychotic medication, it should nevertheless declare that those situations justifying an abridgement of this right are broader in scope than recognized by the First Circuit and District Court. Finally, if this Court were to find that the First Circuit correctly delineated the scope of a constitutional right to refuse treatment, this Court should nevertheless vacate the First Circuit's order remanding the case, to allow defendants to promulgate their

own regulations consistent with the substantive law as set forth in the First Circuit opinion.

By Petitioners' Attorney,

FRANCIS X. BELLOTTI
ATTORNEY GENERAL



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DATED: JULY 1, 1981

APPENDIX TO THE BRIEF

Massachusetts General Laws Chapter 123, § 5. Commitment or retention hearing; right to counsel; independent medical examination; notice

Whenever the provisions of this chapter require that a hearing be conducted in any court for the commitment or further retention of a person to a facility or to the Bridgewater state hospital or to the I.C.U., it shall be held as hereinafter provided. Such person shall have the right to be represented by counsel and shall have the right to present independent testimony. The court shall appoint counsel for such person whom it finds to be indigent and who is not represented by counsel, unless such person refuses the appointment of counsel. The court may provide an independent medical examination for such indigent person upon request of his counsel or upon his request if he is not represented by counsel. The person shall be allowed not less than two

days after the appearance of his counsel in which to prepare his case and a hearing shall be conducted forthwith after such period unless counsel requests a delay. Notice of the time and place of hearing shall be furnished by the court to the department, the person, his counsel, aod his nearest relative or guardian. The court may hold the hearing at the facility or said hospital or at the I.C.U.

Massachusetts General Laws Chapter 123, § 9. Review of matters of law; application for discharge; hearing; discharge

(a) Matters of law arising in commit ment hearings or incompetency for trial proceedings in a district court may be reviewed by the appellate division of the district courts in the same manner as in civil cases generally.

(b) Any person may make written application to a justice of the superior court at any time and in any county, stating that he believes or has reason to

believe that a person named in such application is retained in a facility or the Bridgewater State Hospital or the I.C.U. who should no longer be so retained, giving the names of all persons interested in his confinement and requesting his discharge. The justice within seven days thereof shall order notice of the time and place for a hearing to be given to the superintendent or medical director or director of the I.C.U. and to such other persons as he considers proper; and such hearing shall be given promptly before a justice of the superior court in any county. The justice shall appoint an attorney to represent any applicant whom he finds to be indigent. The alleged mentally ill person may be brought before the justice at the hearing upon a writ of habeas corpus, upon a request approved by the justice. Pending the decision of the court such person may be retained in the

custody of the superintendent or medical director or the director of the I.C.U. If the justice decides that the person is not mentally ill or that failure to retain the person in a facility or the Bridgewater State Hospital would not create a likelihood of serious harm. or finds that the woman in the I.C.U. is not mentally ill; has not engaged in repeated and recent incidents of serious self-destructive behavior or assaultative behavior as an inpatient at a facility or an inmate of a place of detention; can be properly treated in any other facility licensed, operated or regulated by the department or a place of detention in the case of a woman under sentence; and there is not a substantial likelihood that the woman's condition will continue to cause her to inflict serious harm upon herself or others, said persons shall be discharged. If the justice decides that a patient

at the Bridgewater State Hospital does not require strict security, he shall be transferred to a facility.